U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 10 February 2004

CASE NO. 2003-BLA-5355

In the Matter of:

VESTER RAFE OSBORNE,
Claimant

v.

EASTERN ASSOCIATED COAL CORPORATION,
Employer

and

OLD REPUBLIC INSURANCE COMPANY,
Carrier

and

DIRECTOR, OFFICE OF WORKERS COMPENSATION PROGRAMS,
Party-in-Interest

APPEARANCES:

S.F. Raymond Smith, Esquire
For the Claimant

Paul E. Frampton, Esquire
For the Employer/Carrier

Before: RICHARD A. MORGAN
Administrative Law Judge

DECISION AND ORDER-DENYING BENEFITS

This proceeding arises from a claim for benefits filed by Vester Rafe Osborne, a former coal miner, under the Black Lung Benefits Act, 30 U.S.C. §901, et seq. Regulations implementing the Act have been published by the Secretary of Labor in Title 20 of the Code of Federal Regulations.[1]

[1] The Secretary of Labor adopted amendments to the "Regulations Implementing the Federal Coal Mine Health and Safety Act of 1969" as set forth in Federal Register/Vol. 65, No. 245 Wednesday, December 20, 2000. The revised

Black lung benefits are awarded to coal miners who are totally disabled by pneumoconiosis caused by inhalation of harmful dust in the course of coal mine employment and to the surviving dependents of coal miners whose death was caused by pneumoconiosis. Coal workers' pneumoconiosis is commonly known as black lung disease.

A formal hearing was held before the undersigned on July 10, 2003, in Beckley, West Virginia. At that time, all parties were afforded full opportunity to present evidence and argument as provided in the Act and the regulations issued. Furthermore, the record was held open until August 26, 2003 for the submission of closing argument (TR 23-24). The record consists of the hearing transcript, Director's Exhibits 1 through 27 (DX 1-27), and, Employer's Exhibits 1 through 11 (EX 1-11). Although no objection was raised to the admission of the above-referred evidence, and I find that good cause has been shown for the admission of Dr. Fino's report and deposition testimony, I, nevertheless, find that Dr. Fino's serial chest x-ray interpretations exceed the new regulatory limitations. Accordingly, Dr. Fino's serial x-ray readings will not be considered herein (TR 18-22; EX 7,10). In addition, I have received and considered the parties' closing arguments.

The findings of fact and conclusions of law which follow are based upon my analysis of the entire record, including all documentary evidence admitted and arguments made. Where pertinent, I have made credibility determinations concerning the evidence.

Procedural History

Claimant, Vester Rafe Osborne, filed his application for black lung benefits under the Act on January 25, 2001 (DX 1). The District Director issued a Proposed Decision and Order, dated May 9, 2002, awarding benefits (DX 20). By letter dated June 4, 2002, Counsel for Employer/Carrier objected thereto and request reconsideration of the District Director's Proposed Decision and Order (DX 21). Nevertheless, in correspondence dated October 10, 2002, entitled "INITIAL DETERMINATION," the District Director simply cited the eligibility finding of May 9, 2002, and advised the parties and their respective counsel that payments would begin. Furthermore, the District Director noted that he was forwarding the claim to the Office of Administrative Law Judges for a formal hearing (DX 22). By letter dated October 24, 2002, the Carrier rejected the District Director's determination; specifically requested that the case be forwarded to this Office for a formal hearing; and, incorporated by reference the contested issues, as previously presented by counsel for the Employer and Carrier (DX 23). Subsequently, this matter was referred to the Office of Administrative Law Judges for adjudication on January 17, 2003 (DX 25-27). I was assigned the case on February 19, 2003. As previously stated, a formal hearing was held on July 10, 2003, and the record was closed on August 26, 2003 (TR 23-24).

Part 718 regulations became effective on January 19, 2001. Since the current claim was filed on January 25, 2001 (DX 1), the new applications are applicable (DX 27).

Issues

The primary contested issues are as follows:

I. Whether the miner has pneumoconiosis as defined by the Act and the regulations?
II. Whether the miner's pneumoconiosis arose out of coal mine employment?
III. Whether the miner is totally disabled?
IV. Whether the miner's disability is due to pneumoconiosis?

(DX 25; TR 6-7).

Findings of Fact and Conclusions of Law

I. Background

A. Coal Miner and Length of Coal Mine Employment

The parties stipulated, and I find, that Clamant engaged in coal mine employment for approximately 20 years ending in May 1987 (DX 1, 2, 25; TR 8-9).

B. Date of Filing

As previously stated, Claimant filed his application for benefits under the Act on January 25, 2001 (DX 1). The timeliness of this filing is not contested (DX 25).

C. Dependents

Claimant has one dependent for purposes of possible augmentation of benefits under the Act; namely, his wife, Shirley Mae Osborne (nee Browning). (DX 1, 5; TR 8).

D. Personal, Employment, and Smoking History

Claimant was born on September 25, 1947; he completed an 11th grade education. As stated above, I find that Claimant engaged in coal mine employment for approximately 20 years. His last usual coal mine job was as a mechanic/electrician for Eastern Associated Coal Company, the properly designated responsible operator, ending in May 1987, when he was injured by falling rock (DX 1, 2, 3; TR 8-9). All of Claimant's coal mine work was spent underground (TR 9-10). Claimant's primary job duty was to work on equipment. The ceiling where he worked was 10 to 14 feet in height. Claimant testified that the job entailed lifting oil and mechanical parts that he used while working on the equipment. He estimated that the weight of five gallons of oil is approximately 50 pounds (TR 10). However, as discussed below, the reports of the examining physicians suggest that the physical requirements of Claimant's last usual coal mine job may have been more extensive than that which he described in his testimony. Dr. Rasmussen reported that Claimant's coal mine job as a mechanic/electrician entailed carrying items weighing 50-70 pounds a distance of 200 feet and "much heavy lifting, shoveling. Considerable heavy manual labor." (DX 6). Similarly, Dr. Zaldivar that the job involved "heavy

lifting, pulling, pushing, and carrying." (EX 5). Accordingly, while Claimant's testimony suggests that his last usual coal mine job only entailed mild-to-moderate exertion, the reports of the examining physicians indicate that it involved heavy manual labor.

Claimant testified that he filed two claims for occupational pneumoconiosis benefits with the State of West Virginia, and the total award for both claims indicated a 20% disability. Claimant testified that the second award was in 1993. Since then, he has not received any additional benefits; however, he did receive a health card (TR 10-11). Claimant's testimony regarding the State awards is borne out by the documentary evidence, which includes a ruling by State Administrative Law Judge Jack M. Marden, dated March 15, 2003, in which Judge Marden reversed a Commissioner's Order, dated May 10, 1991, and found that Claimant should be granted an additional 15% permanent partial disability award, based upon his finding that Claimant "has a 20% whole man impairment due to occupational pneumoconiosis." (DX 4).[2]

Although Claimant's testimony did not address his cigarette smoking history, the medical evidence contains substantial contradictions in the reported smoking histories. For example, when Claimant was examined by Dr. Rasmussen on May 24, 2001, he apparently advised Dr. Rasmussen that he had only smoked 1 pack per day during the period from 1963 to 1973 (DX 6). Similarly, when he was examined by Dr. Zaldivar on July 18, 2001, Claimant apparently told Dr. Zaldivar that he "began smoking at age 15 or 16" (*i.e.,* 1962 or 1963) and quit smoking "25 years ago" (*i.e.,* 1974). On the other hand, when Claimant was admitted to Princeton Community Hospital on July 15, 1987 due to a "pulmonary nodule," he reportedly had smoked "approximately 15-20 yrs.," and he was still smoking one pack of cigarettes per day (EX 1). Moreover, when Claimant was hospitalized on May 25, 1995 with pleuritic chest pain, the reported "Psychosocial History" was as follows: "The patient smokes 2 packs of cigarettes per day for many years. He is an ex-coal miner." (EX 1).

I find that there is little reason for Claimant to have inflated his actual cigarette smoking history, since such action could undermine his black lung claim. On the other hand, understating his cigarette smoking history is self-serving. Having weighed the conflicting evidence set forth above and the physicians' reports outlined below, I find that, taken as a whole, Claimant has a very significant smoking history, which is far greater than what he apparently told Drs. Rasmussen and Zaldivar.

II. Medical Evidence

The medical evidence includes various chest x-rays, pulmonary function studies, arterial blood gases, and physicians' opinions, including CT scan interpretations, which are summarized below.

[2] The State award is not binding herein, since the underlying statutes, regulations, and evidence are not the same as those which apply in this Federal black lung claim.

A. Chest X-rays

The case file contains numerous descriptive interpretations of chest x-rays which were administered during the period from April 12, 1973 through August 4, 1995 (EX 1). Some of the early x-rays were interpreted as normal or negative, while others indicated various abnormalities. However, none of the above-referred x-rays were read as positive for pneumoconiosis under the classification requirements set forth in §718.102(b). Moreover, in view of the progressive and irreversible nature of pneumoconiosis, I find that the interpretations of these older x-rays are less probative than those of the significantly more recent films, dated May 24, 2001 (DX 10/11,12; EX 2), July 18, 2001 (EX 3), and July 31, 2001 (EX 8), respectively.

Of the foregoing, Dr. Patel's 1/0 reading of the May 24, 2001 film is the only positive interpretation for pneumoconiosis under the classification requirements set forth in §718.102(b). (DX 10/11). Dr. Binns reread the same film for quality purposes only (DX 12). However, Dr. Gayler interpreted the same chest x-ray as completely negative (EX 2). Moreover, Dr. Scott and Dr. Scatarige interpreted films dated July 18, 2001 (EX 3) and July 31, 2001 (EX 8), respectively, as negative for pneumoconiosis, while noting other abnormalities. All of the above-named physicians are dual-qualified B-readers and Board-certified radiologists.

In summary, three of the four substantive interpretations by dual-qualified B-readers and Board-certified radiologists are negative for pneumoconiosis. Therefore, I find that Claimant has failed to establish pneumoconiosis by a preponderance of the x-ray evidence.

B. Pulmonary Function Studies

A claimant must show he is totally disabled and that his total pulmonary disability is caused by pneumoconiosis. The regulations set forth criteria to be used to determine the existence of total disability which include the results of pulmonary function studies and arterial blood gas studies.

The record contains pulmonary function studies which were performed on May 24, 2001 (before bronchodilator) (DX 9) and July 18, 2001 (before and after bronchodilator) (EX 5), respectively. None of the tests are qualifying under the applicable criteria set forth in 20 C.F.R. 718, Appendix B. Moreover, the foregoing studies were interpreted as either "normal" or as showing only a "mild" impairment. Therefore, I find that such evidence clearly does not establish the presence of a totally disabling pulmonary or respiratory impairment.

C. Arterial Blood Gas Studies

Blood gas studies are performed to detect an impairment in the process of alveolar gas exchange. This defect will manifest itself primarily as a fall in arterial oxygen tension either at rest or during exercise. The record includes arterial blood gas studies which were administered on May 29, 1995 (EX 1), May 31, 1995 (EX 1), and June 20, 2001 (resting and exercise) (DX 7). The latter was reviewed by Dr. Ranavaya, who indicated by a check mark that the June 20, 2001 study was technically acceptable (DX 8). Of the foregoing tests, only the June 20, 2001 exercise

test is qualifying under the regulatory standards set forth in 20 C.F.R. Part 718, Appendix C. In view of the progressive and irreversible nature of pneumoconiosis, I accord greater weight to the significantly more recent studies, dated June 20, 2001. Since the results obtained at rest are nonqualifying, and the exercise results are qualifying, I find that the arterial blood gas evidence, taken as a whole, neither precludes nor establishes the presence of a totally disabling pulmonary or respiratory impairment.[3]

D. Physicians' Opinions (including CT Scan evidence)

The case file includes records from Princeton Community Hospital (EX 1) and Appalachian Regional Healthcare;[4] and, the medical opinions of Drs. Wheeler (EX 9), Scott (EX 9), Scatarige (EX 9), Rasmussen (DX 6), Zaldivar (EX 5,6), Branscomb (EX 4,11), and Fino (EX 7, 10).

The Princeton Community Hospital records cover the period from July 15, 1987 to January 21, 1988, and includes the following: multiple chest x-ray readings in July 1987 and January 21, 1988, which do not constitute medical opinion evidence; Dr. Muldoon's "Report of Consultation," dated July 15, 1987; a CT scan report, dated July 16, 1987, and the Discharge Summary, dated July 20, 1987 (EX 1).

Dr. John D. Muldoon, III, issued a hospital consultation report, dated July 15, 1987, in which he listed Claimant's chief complaint as a "Pulmonary nodule." His assessment was as follows:

1. Cervical radiculopathy.
2. Left lung nodule with increased left lower lung markings, etiology undetermined at this point. The possibilities would include benign granuloma, previous pulmonary infection. Certainly with his history of tobacco abuse a malignancy cold not be eliminated.
3. Peptic ulcer disease, status post-gastrectomy, currently doing well.
4. Tobacco abuse.

(EX 1).

[3] Claimant testified that when Dr. Rasmussen first examined him (*i.e.,* May 24, 2001), he was unable to get a cannula in the artery, despite several attempts to do so. However, when Claimant went back the second time to see Dr. Rasmussen (*i.e.,* June 20, 2001), he was able to do so and obtain resting and exercise blood gas studies (TR 15-16; DX 7). Claimant testified that Dr. Zaldivar also tried to get the cannula in his artery on two separate dates. However, Dr. Zaldivar's efforts to cannulate the artery were unsuccessful (TR 14-15; EX 5).

[4] The Oceana Medical Center records from March 30, 1984 to January 4, 1993 consist of multiple chest x-ray readings, which do not constitute medical opinion evidence.

Dr. E. Cappiello issued a CT scan report, dated July 16, 1987, in which he stated, in pertinent part:

> IMPRESSION: Small 1 cm. Diameter oval shaped nodule in the left upper lobe. This must be considered an indeterminate nodule. This nodule may well represent a granuloma, however neoplasm cannot entirely be excluded. For this reasons, as well as its size, this patient should be followed with chest x-rays at 3 month intervals at least for a year and if any increase in size occurs, repeat CT should be obtained.

(EX 1).

The Princeton Community Hospital Discharge Summary, dated July 20, 1987, indicates that Claimant was hospitalized from July 15, 1987 to July 20, 1987; and, that he underwent an "anterior discectomy, interbody fusion, C5/6" on July 16, 1987, with no complications. The discharge diagnoses were as follows:

> PRINCIPAL DIAGNOSIS:
>
> Right C6 radiculopathy secondary to degenerated herniated nucleus pulpous and osteophyte compression at the root exit zone at C5/6.
>
> SECONDARY DIAGNOSIS:
>
> Left upper lobe pulmonary nodule, probable granuloma.

(EX 1).

The Appalachian Regional Healthcare medical records include the following: various x-ray interpretations of the abdomen and/or chest administered in 1973, 1982, and 1990; a History and Physical Examination report, dated May 29, 1995, which lists an admitting diagnosis of pneumonia; arterial blood gas results obtained on May 29, 1995 and May 31, 1995; various chest x-rays interpretations obtained in 1995, noted above; and, a CT scan report, dated December 3, 1999 (EX 1). Except for the CT scan report, none of the foregoing constitute relevant medical opinion evidence.

The CT scan report by Dr. Benny O. Iko, dated December 3, 1999, states, in pertinent part:

> CONCLUSION: 1. Normal-sized hilar lymph nodes. No confluence and the usual CT criteria for pathology are not met.
> 2. The lung fields are clear.

(EX 1).

Dr. Paul S. Wheeler, a B-reader and Board-certified radiologist, interpreted the December 3, 1999 CT scan as follows:

> 10 mm lung and mediastinal settings with IV contrast: No pneumoconiosis.
>
> Possible subtle focal infiltrates in upper anterior lungs near pleura on 2 sets of lung settings. Check clinically for pneumonia.
> Probable gravity induced pulmonary vascular prominence in posterior and lower lungs accentuated by respiratory motion and light lung settings.
>
> Surgery near gastroesophageal junction, clip on posterior left diaphragm dome and tiny calcified granuloma in right subcarinal node.
>
> Surgical clips in anterior inferior right lobe liver compatible with partial resection. Dense pills in posterior gastric fundus.
> Quality: Light lung settings some with respiratory motion.

(EX 9).

Dr. William W. Scott, Jr., a B-reader and Board-certified radiologist, issued a report, dated May 13, 2003, in which he interpreted a chest CT scan, dated December 3, 1999, as follows:

> No evidence of silicosis / CWP.
>
> Minimal infiltrates anterior portion both mid-upper lungs: possible pneumonia. Atypical tuberculosis can sometimes have this distribution.
>
> Surgical clips upper abdomen.
>
> Retained food and secretions and possibly pills in stomach. The fact that the stomach has been filled with material on all chest exams indicates abnormal gastric emptying.

(EX 9).

Dr. John C. Scatarige, a B-reader and Board-certified radiologist, also interpreted the chest CT scan, dated December 3, 1999. In his report, dated May 13, 2003, Dr. Scatarige stated:

> **Results:**
>
> 1. No CT evidence of CWP or silicosis.
>
> 2. Subtle nodular ground glass infiltrates in anterior bilateral upper lobes and more diffuse ground glass infiltrates in both lower lungs. Suggest clinical correlation for pneumonia.

3. Few calcified mediastinal and hilar nodes, compatible with old granulomatous disease.

4. Oval 1 cm nodule in LLL lateral to left hilum, unchanged from prior CXR and probably a granuloma.

5. Surgical clips at EG junction and radiopaque pills in stomach.

6. Calcifications in anterior segment right lobe liver: old trauma or infection.

(EX 9).

Dr. D.L. Rasmussen, who is Board-certified in Internal Medicine and Forensic Medicine, examined Claimant on May 24, 2001 (DX 6). On a U.S. Department of Labor form, Dr. Rasmussen reported Claimant's last coal mine employment history as follows: "Electrician and mechanic underground. Carried tools – 50-70# 200+ feet – rock dust 50#. Much heavy lifting, shoveling. Considerable heavy manual labor." In addition, Dr. Rasmussen reported Claimant's "Other CME" as follows: "1968-1987-Continuous miner operator, loading machine operator, roof bolter, electrician and mechanic." Dr. Rasmussen also set forth Claimant's family, medical, and social histories. As previously stated, Dr. Rasmussen reported that Claimant smoked 1 pack of cigarettes, and, that he had smoked from 1963 to 1973 (DX 6, Sec. C3). Claimant's subjective complaints included sputum, wheezing, dyspnea, cough, chest pain, orthopnea, ankle edema, and paroxysmal nocturnal edema (DX 6, Sec. D1). On physical examination, Dr. Rasmussen reported "normal" findings, including "normal" breath sounds and "no rales, rhonchi or wheezes." (DX 6, Sec. D4). Furthermore, Dr. Rasmussen discussed various clinical test results. All were obtained on May 24, 2001, except for the arterial blood gases, which were conducted on June 20, 2001. In the "Summary of Results" section of the form report, Dr. Rasmussen set forth the following:

Chest X-ray:	Pneumoconiosis s/s 1/0 all zones.
Vent Study (PFS):	Normal.
Arterial Blood Gas:	Marked impairment in oxygen transfer with exercise.
Other:	SBDLCO moderately reduced.

(DX 6, Sec. D5).

Under the Cardiopulmonary Diagnoses section of the U.S. Department of Labor form report, Dr. Rasmussen set forth the following diagnoses and bases for his findings:

1. CWP – 20 years coal mine employment and x-ray evidence of pneumoconiosis.
2. Chronic Bronchitis – Chronic productive cough.

(DX 6, Sec. D6). Regarding the etiology of the foregoing conditions, Dr. Rasmussen related both diagnoses to coal dust exposure (DX 6, Sec. D7). When asked the severity of Claimant's impairment from a chronic respiratory or pulmonary disease, if any, Dr. Rasmussen stated: "The patient has marked loss of lung function as reflected by his marked impairment in oxygen

transfer during exercise. He does not retain the pulmonary capacity to perform his last regular coal mine job." (DX 6, Sec. 8a). When asked the extent to which each of the diagnosed conditions contributes to Claimant's impairment, Dr. Rasmussen stated: "His coal mine dust exposure is the primary cause of his disabling lung disease." (DX 6, Sec. D8b).

Dr. Rasmussen also issued a typewritten report, dated July 6, 2001, which reiterates the above-referred findings (DX 6). In summary, Dr. Rasmussen stated:

> **PHYSICAL EXAMINATION:** …Chest expansion and diaphragmatic excursions are normal. Breath sounds are normal…
>
> A chest x-ray interpreted by Manu N. Patel, a Board Certified Radiologist and B-reader, indicated pneumoconiosis s/s with a profusion of 1/0 throughout all lung zones.
>
> The patient's electrocardiogram was within normal limits.
>
> **LABORATORY STUDIES:** Ventilatory studies were normal. Maximum breathing capacity was minimally reduced; however, it was less than the calculated value of 130L/min. The single breath carbon monoxide diffusing capacity was moderately reduced at 47% of predicted.
>
> …Resting blood gases were normal.
>
> The patient underwent an incremental treadmill exercise study beginning at 2.5 mph at a 0% grade. The level was maintained for 3 minutes and thereafter the grade of the treadmill was increased at 3% per minute. The patient exercised for 8 minutes and reached a maximum of 2.5 mph at a 15% grade. He achieved an oxygen uptake of 22.2 cc/kg/min., which was 64% of his predicted maximum oxygen uptake. He denied chest pain. His EKG and BP responses were normal. He exceeded his aerobic threshold normally at about 43% of his predicted maximum oxygen uptake. His heart rate was within normal limits. His volume of ventilation was markedly increased. He retained a breathing reserve of only 32 L/min. There was minimal increase in VD/VT ratio. Oxygen transfer was markedly impaired and markedly hypoxic.
>
> These studies indicate marked loss of lung function as reflected by reduced diffusing capacity and marked impairment in oxygen transfer during exercise. This degree of impairment would render this patient totally disabled for resuming his last regular coal mine job with its attendant requirement for heavy manual labor.
>
> The patient has a significant history of exposure to coal mine dust and x-ray changes consistent with pneumoconiosis. It is medically reasonable to conclude that he has coalworkers' [sic] pneumoconiosis which arose from his coal mine employment.

> The only significant risk factor for this patient's disabling lung disease is his coal mine dust exposure.

(DX 6).

Dr. George L. Zaldivar, a B-reader, who is Board-certified in Pulmonary Disease, Internal Medicine, Sleep Disorder, and Critical Care Medicine, examined Claimant on July 18, 2001 (EX 5). In a "History & Physical Examination" report on that date, Dr. Zaldivar set forth Claimant's chief complaint of "Chest pain and shortness of breath;" history of present illness; and, past medical history. As set forth above, Dr. Zaldivar reported a smoking history beginning at age 15 or 16, and ending 25 years ago. Furthermore, Dr. Zaldivar reported the following work history:

> In 1987 he quit the mines after the back injury, and he worked for 20 years. He was a mechanic/electrician for 4 years. He had to do heavy lifting, pulling, pushing, and carrying. He says that he was in the slate fall crew. When that happened, the miner was used to clear it out. There was shoveling and timbering to be done with it, too. If there was no slate fall, then he was put on operating the equipment. He says that before then he was a roof bolter. As part of his job, he had to carry heavy headers, which required the help of someone else because they were 16 feet long. He worked in a sawmill before then. He was never in the Armed Forces.

(EX 5). In addition, Dr. Zaldivar set forth Claimant's personal and social history; family and personal illnesses; review of systems; and, findings on physical examination. In summary, Dr. Zaldivar stated:

> **IMPRESSION:**
>
> 1. History of epigastric pain, which may be stomach problems due to stomach ulcers and reflux.
> 2. Normal examination of the lungs.
> 3. History of shortness of breath.
> 4. History of back pain.

(EX 5).

In a supplemental report, dated September 17, 2001 (EX 5), Dr. Zaldivar set forth his own clinical findings, as set forth above. In addition, Dr. Zaldivar reviewed and analyzed other available evidence. Based upon the foregoing, Dr. Zaldivar stated:

> My own findings are as follows:
>
> 1. Summary of the history and physical examination as listed under "Impression."
> 2. High carboxyhemoglobin of a current smoker.
> 3. Mild irreversible airway obstruction.
> 4. Air trapping by lung volumes.

5. Moderate diffusion impairment.
6. Abnormal chest x-ray compatible with interstitial fibrosis unrelated to coal worker's pneumoconiosis.

COMMENTS

I was unable to cannulate the artery of Mr. Osborne as noted in the enclosed report. Mr. Osborne, according to the records which you sent me, has been worked up in the past for a nodule in his lung. The older x-rays did not show any abnormalities in the lung bases as mine does. These abnormal radiographic findings are not typical of coal worker's pneumoconiosis which is first seen in the upper zones of the lungs. The abnormalities exhibited on Mr. Osborne are those of interstitial fibrosis. These abnormalities are seen in smokers because of inflammation of the area around the bronchi caused by smoking. In his case, the diffusing capacity is reduced which means that there is, in fact, damage to the lung tissue from interstitial fibrosis which may well be caused by his smoking habit.

Mr. Osborne does not have coal worker's pneumoconiosis nor any dust disease of the lungs. Mr. Osborne may have interstitial fibrosis as noted by the reduced diffusing capacity and abnormal chest x-ray. The cause of the fibrosis is unknown, but may be related to his smoking habit. From the pulmonary standpoint, he is capable of performing his usual coal mining work or work requiring similar exertion according to the measurements made in my office.

(EX 5).

Dr. Zaldivar issued another supplemental report, dated May 7, 2003, in which he reviewed additional medical data. Following his analysis of the evidence, as well as citation to medical literature, Dr. Zaldivar concluded:

OPINIONS

Taking all of this information into consideration, my opinion remains the same as given on 09/17/2001. Mr. Osborne suffers from pulmonary fibrosis unrelated to coal worker's pneumoconiosis. His physiological abnormalities and the chest x-ray are typical of individuals with such disorder. Mr. Osborne according to the Diffusing Capacity test, is expected to have hypoxemia during exercise as found by Dr. Rasmussen because of the nature of his disease. In cases such as his, it is advisable to perform an open lung biopsy to characterize the nature of the pulmonary fibrosis and treat if possible. Mr. Osborne does not have coal worker's pneumoconiosis nor does he suffer from pulmonary deficits resulting from any such pneumoconiosis which he does not have.

(EX 5). Dr. Zaldivar reiterated the foregoing conclusion in his testimony at deposition held on June 2, 2003. Furthermore, Dr. Zaldivar clarified his opinion, and specified that his finding of no pneumoconiosis included both medical and legal pneumoconiosis (EX 6).

Dr. Ben V. Branscomb is a pulmonary specialist with "a very rich and continuing experience in managing all sorts of pulmonary problems, particularly in coal miners." He was the first person to develop the Flow Volume Loop; and, he started in the field of pulmonary diseases before it was a recognized medical specialty (EX 11, pp. 3-6); *See also* EX 4). In his report, dated May 22, 2003 (EX 4), Dr. Branscomb set forth a detailed summary of the available data. Following his discussion of Claimant's coal mine dust exposure, conflicting smoking histories, various clinical test results, and medical opinions, Dr. Branscomb stated:

> **CONCLUSIONS:** I concur in the medical opinion that simple CWP is sometimes disabling, that CWP can be a progressive disorder first manifest after mining stops, that its manifestations may be latent, and that sometimes coal mine dust or CWP produce obstructive manifestations. I also incorporate in my definition of CWP for this report the concept that any pulmonary disorder or impairment in any way caused or significantly aggravated by either coal mine dust or CWP is regarded as pneumoconiosis. Further, I accept the concept that disability caused by a non-occupational disorder which has been materially worsened by either coal mine dust or CWP is included as a disability attributable, at least in part, to CWP.
>
> My conclusions which follow are made with a high level of medical certainty or probability:
>
> There is no medically reasonable objective basis for diagnosis either medical or legal CWP in Mr. Osborne's case. There are adequate confirmed explanations for his complaints of shortness of breath and exercise intolerance. These include spinal cord injury and surgery, hypertensive cardiovascular disease with coronary disease demonstrated by cardiac catheterization, angina pectoris, and mild or moderate obesity.
>
> There is no ventilatory impairment whatsoever. He can move the same amount of air to and fro at the same speed as the healthy volunteers from whom the standards were derived. There may be a mild amount of air remaining in the chest at the end of a forced expiration. That is, a mildly increased amount of air trapped in the residual volume. If so it is not influencing Mr. Osborne's ventilatory capacity. If this is present it is the result of emphysema caused by cigarette smoking. I suggest that early emphysema may be present. If so it is of the type identified in smoking, with mildly reduced DLCO and mild impairment in oxygen ventilation relationships.
>
> In my judgement [sic], based on all the records, Mr. Osborne does not have pulmonary impairment of any etiology severe enough to prevent his previous coal mine work. The finding of one low exercise oxygen value when two persons have been unable to cannulate the artery successfully and when the barometric pressure was not incorporated into the decision making, in a person with a negative chest x-ray and normal spirograms, is, medically speaking, an insufficient basis for assuming disabling pulmonary disease is present. Furthermore, the specific combination has not been proved to occur either as a result of coal mine dust exposure or as a result of x-ray negative CWP.

If I assume CWP is present I would still conclude pulmonary function is ample for his previous coal mine or similarly demanding work.

(EX 4). In his deposition testimony on June 26, 2003, Dr. Branscomb reiterated the above-stated opinion (EX 11).

Dr. Gregory J. Fino, a B-reader who is Board-certified in Internal Medicine and Pulmonary Disease, issued a detailed, 18+ page report, dated June 18, 2003, in which he thoroughly reviewed and analyzed the available evidence (EX 7). Following his summary of the relevant evidence, Dr. Fino concluded:

Discussion

This man does not have a ventilatory impairment. The FVC and FEV1 are entirely within normal limits. However, he has a significant oxygen transfer impairment. This has been corroborated by the reduction in diffusing capacity noted on the evaluations of Dr. Zaldivar and Dr. Rasmussen. In his examination of 7/18/01, Dr. Zaldivar noted interstitial changes at the bases.

I believe this man does have a pulmonary disability due to his interstitial pulmonary fibrosis. This is not a disease related to coal mine dust inhalation; it is a disease of the general medical population. There is no reasonable medical evidence that interstitial pulmonary fibrosis is caused by the inhalation of coal mine dust. What has developed in this man is a lung disease unrelated to the inhalation of coal mine dust.

He is disabled from a pulmonary standpoint. However, his disability was neither caused by, contributed to, nor hastened by the inhalation of coal mine dust.

(EX 7). Dr. Fino reiterated the foregoing conclusion in his testimony at deposition held on June 23, 2003 (EX 10).

Pneumoconiosis

Section 718.202 provides four means by which pneumoconiosis may be established. Under §718.202(a)(1), a finding of pneumoconiosis may be made on the basis of the x-ray evidence. As stated above, the clear preponderance of the x-ray evidence, which consists of various substantive interpretations by dual-qualified B-readers and Board-certified radiologists, is negative for pneumoconiosis. Therefore, I find that the presence of pneumoconiosis has not been established under §718.202(a)(1).

Under §718.202(a)(2), a finding of pneumoconiosis may be made on the basis of biopsy or autopsy evidence. In the absence of any such evidence, this subsection is not applicable.

Section 718.202(a)(3) provides that pneumoconiosis may be established if any one of several cited presumptions are found applicable. In the instant case, the presumption of §718.304 does not apply because there is no evidence in the record of complicated

pneumoconiosis. Section 718.305 is inapplicable to claims filed after January 1, 1982. Finally, the presumption of §718.306 does not apply to living miner's claims. Therefore, the Claimant cannot establish pneumoconiosis under §718.202(a)(3).

Under §718.202(a)(4), a determination of the existence of pneumoconiosis may be made if a physician exercising reasoned medical judgment, notwithstanding a negative x-ray, find that the miner suffers from pneumoconiosis as defined in §718.201. Pneumoconiosis as defined in §718.201 means a chronic dust disease of the lungs and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both "Clinical Pneumoconiosis" and "Legal Pneumoconiosis." *See* 20 C.F.R. §718.202(a)(1) and (2).

As summarized above, the case file includes records from Princeton Community Hospital (EX 1) and Appalachian Regional Healthcare; and, the medical opinions of Drs. Wheeler (EX 9), Scott (EX 9), Scatarige (EX 9), Rasmussen (DX 6), Zaldivar (EX 5,6), Branscomb (EX 4,11), and Fino (EX 7,10).

The records from Princeton Community Hospital and Appalachian Regional Healthcare establish that Claimant has a history of various medical problems, including some which are pulmonary-related, such as a "pulmonary nodule" and "pneumonia." However, such evidence does not establish the presence of pneumoconiosis. Moreover, the CT scan, dated December 3, 1999, which was administered at Appalachian Regional Healthcare, was interpreted by Dr. Iko as showing clear lung fields. Furthermore, as discussed herein, the medical records establish that Claimant has a significant cigarette smoking history (EX 1).

The opinions of Drs. Wheeler, Scott and Scatarige are limited to their interpretations of the CT scan, dated December 3, 1999. Although all three physicians found various abnormalities, they all agreed that the CT scan is negative for pneumoconiosis (EX 9).

Of the remaining physicians' opinions, Dr. Rasmussen is the only one who found that Claimant suffers from coal worker's pneumoconiosis and that coal mine dust exposure caused Claimant's disabling lung disease. On the other hand, Drs. Zaldivar, Branscomb, and Fino found that Claimant does not have (clinical or legal) pneumoconiosis, and that Claimant's pulmonary or respiratory impairment, if any, is wholly unrelated to pneumoconiosis and/or his coal mine employment.

In weighing the foregoing opinions, I note that Dr. Rasmussen relied, at least in part, upon a questionable positive chest x-ray reading of pneumoconiosis, which is inconsistent with the preponderance of the x-ray and CT scan evidence. Moreover, Dr. Rasmussen relied upon a grossly understated cigarette smoking history of one pack per day from 1963 to 1973, as evidenced by his conclusion that Claimant's coal mine dust exposure was the "only significant risk factor for [Claimant's] disabling lung disease." (DX 6).[5] Furthermore, Dr. Rasmussen's opinion is based on the limited information he obtained in conjunction with his examination of Claimant on May 24, 2001, ending with the June 20, 2001 arterial blood gas studies. It is unclear whether Dr. Rasmussen would have had the same opinion regarding the pneumoconiosis and

[5] Although Dr. Zaldivar reported a similar smoking history, he correctly questioned its accuracy, noting Claimant had the "high carboxyhemoglobin of a current smoker." (EX 5).

causation issues if he had known that the clear preponderance of the x-ray and CT scan evidence was negative for pneumoconiosis and that Claimant's cigarette smoking history was far more extensive than he reported. Unlike Drs. Zaldivar, Branscomb, and Fino, Dr. Rasmussen did not consider other evidence, such as the hospital records, CT scan interpretations or clinical test results and findings by other physicians. Moreover, Drs. Zaldivar, Branscomb, and Fino provided more detailed explanations regarding how the relevant medical data correspond with their opinions regarding the etiology of Claimant's pulmonary or respiratory impairment. In view of the foregoing, I accord greater weight to the opinions rendered by Drs. Zaldivar, Branscomb, and Fino than that of Dr. Rasmussen regarding the "pneumoconiosis" and "causation" issues. Accordingly, I find that Claimant has failed to meet his burden of establishing pneumoconiosis under §718.202(a)(4), or by any other means.

I have also weighed all the relevant evidence together under 20 C.F.R. §718.202(a) to determine whether the miner suffered from pneumoconiosis. Since neither the x-ray evidence nor the medical opinion evidence is sufficient to establish pneumoconiosis, I find that pneumoconiosis has not been established under 20 C.F.R. §718.202(a). *See, Island Creek Coal Co. v. Compton*, 211 F. 3d 203, 2000 WL 524798 (4th Cir. 2000); *Penn Allegheny Coal Co. v. Williams,* 114 F. 3d 22 (3d Cir. 1997).

Causal Relationship

Since Claimant has failed to establish the presence of (clinical or legal) pneumoconiosis, he also cannot establish that the disease arose from his coal mine employment. If Claimant had established the existence of pneumoconiosis, however, he would be entitled to the rebuttable presumption that the disease arose from his more than ten years of coal mine employment. 20 C.F.R. §718.203.

Total Disability Due to Pneumoconiosis

Notwithstanding the clearly nonqualifying pulmonary function studies and the mixed arterial blood gas evidence, the medical opinion evidence indicates that Claimant is totally disabled within the meaning of §718.204(b), *if Claimant's last usual coal mine job entailed heavy manual labor.* In making this determination, I note that Dr. Rasmussen was the only physician who was able to obtain an exercise blood gas study. Based upon the qualifying results thereof, Dr. Rasmussen clearly stated that Claimant could not return to his last usual coal mine job "with its attendant requirement for heavy manual labor." (DX 6). Dr. Rasmussen's finding of total disability is supported by Dr. Fino's opinion regarding this issue (EX 7,10). On the other hand, Dr. Zaldivar, who also described Claimant's last job as entailing heavy manual labor, found that Claimant has the pulmonary capacity to perform "his usual coal mining work or work requiring similar exertion *according to the measurements made in my office.*" (EX 5). (Emphasis added). Since Dr. Zaldivar was unable to obtain an exercise blood gas study, he did not record any measurements in his office for such test. It is unclear whether Dr. Zaldivar would have reached the same conclusion regarding the total disability issue based on the measurements made in Dr. Rasmussen's office, which included the qualifying exercise blood gas test. Therefore, I accord Dr. Zaldivar's ambiguous statement regarding the total disability issue less weight. I have also considered the reviewing opinion of Dr. Branscomb, who opined that the one

qualifying exercise blood gas study is insufficient to find that Claimant has a disabling pulmonary disease. Nevertheless, I find that the preponderance of the medical opinion evidence, in conjunction with the qualifying exercise blood gas test, establishes that Claimant cannot perform his last usual coal mine job, *if it requires heavy manual labor*.

As stated above, the exertional requirements of Claimant's last usual coal mine employment as a mechanic/electrician are somewhat ambiguous, because it is unclear whether Claimant understated the requirements during his testimony, or exaggerated the duties in his statements to the examining physicians. Nevertheless, for the purpose of rendering a decision herein, I find that Claimant suffers from a totally disabling pulmonary or respiratory impairment. However, since Claimant has not established (clinical or legal) pneumoconiosis by a preponderance of the evidence, he has also failed to establish total disability due to pneumoconiosis, as defined in §718.204(c).

Conclusion

Having considered the relevant evidence, I find that Claimant has not established the presence of pneumoconiosis and/or total disability due to pneumoconiosis. Accordingly, Claimant is not eligible for benefits under the Act and regulations.

ATTORNEY FEES

The award of attorney's fees, under the Act, is permitted only in cases in which the claimant is found to be entitled to the receipt of benefits. Since benefits are not awarded in this case, the Act prohibits the charging of any fee to the claimant for the representation services rendered to him in pursuit of the claim.

ORDER

It is ordered that the claim of Vester Rafe Osborne, for benefits under the Black Lung Benefits Act is hereby **DENIED.**

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RICHARD A. MORGAN
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within thirty (30) days from the date of this Decision and Order, by filing a notice of appeal with the ***Benefits Review Board at P.O. Box 37601, Washington, D.C. 20013-7601.*** A copy of a notice of appeal must also be served on Donald S. Shire, Esquire, Associate Solicitor for Black Lung Benefits, Frances Perkins Building, Room B2117, 200 Constitution Avenue, N.W., Washington, D.C. 20210.